Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a 03400

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town SPRINGFIELD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME SALLY JO ANSEL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 3, 1947

8. AGE: Years 5 Months Days 25 If less than one day hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name WILSON MONROE ANSEL
13. Birthplace W.VA.

MOTHER
14. Maiden name IRIS GERTRUDE HAMILTON
15. Birthplace W.VA.

16. Informant W. M. Ansel.

Address Springfield, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30-48 (month) (day) (year)

Cemetery or crematory Springfield

Location Romney, W.Va

18. Funeral director H.C. Ruckman

Address Romney, W.Va.

19. April 28 1948 Hunter R. Trusty M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28, 1948 19 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 19 48 and that I last saw h alive on April 27 19 48

Immediate cause of death	DURATION
Meningitis	4 days
Due to Undetermined origin	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson M.D.
(M. D. or other)

Address Cumberland Md. Date signed 4-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03401

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State TERRA ALTA W. VA. County PRESTON
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME BEATTY SUE J. MRS.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife BEATTY LAFAYETTE W.
6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) AUG 30, 1866

8. AGE: Years	Months	Days	If less than one day
81	7	22	hrs. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual occupation HWFE
11. Industry or business
FATHER 12. Name DE BERRY JOSEPH
13. Birthplace W.VA.
MOTHER 14. Maiden name HERRING, SUSAN
15. Birthplace W.VA.
16. Informant Memorial Hospital
Address Cumberland, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof April 22 48 (month) (day) (year)
Cemetery or ~~crematory~~ Terra alta W.Va.
Location Terra alta. W.Va.
18. Funeral director A. F. Collins
Address Terra alta. W.Va.
19. April 22, 48 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/48 19 at 8:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1948 to April 22 1948 and that I last saw h... alive on April 22 1948

Immediate cause of death	DURATION
a Obstructive Carcinoma Rectosigmoid	
Due to b Carcinomatosis	
Due to c Abdomen	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation Carcinomatosis Abdomen
Date of op. 4-17-48
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A.H. Kaufmann M. D. or other
Address Date signed

Write in corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03402

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL Hospital
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town KITZMILLER -
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME ETHEL BENDER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife STANLEY BENDER 6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) March 1, 1878

8. AGE: Years 70 | Months 1 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND, Kitzmiller, Garrett Co.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN [redacted] Henry Rafter
13. Birthplace W.VA.

MOTHER
14. Maiden name VICTORIA Ellen KITZMILLER
15. Birthplace MARYLAND

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12 1948 (month) (day) (year)
Cemetery or crematory I.O.O.F. Cem.
Location Elk Garden, W. Va.

18. Funeral director Otha L. Shaffer
Address Blaine, W. Va.

19. April 12 1948 W. L. Tantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9, 1948 19 at 1:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-28- 19 48 to 4-9- 19 48
and that I last saw her alive on 4-9- 19 48

Immediate cause of death Chronic Pyelonephritis with Uremia — DURATION

Due to.

Due to.

Other conditions Arteriosclerosis Myocardial degeneration
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Folson M.D.
M. D. or other
Address Cumberland Md Date signed 4-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03403

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Allegany

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Thomas William Bennett

3.(b) Social Security Number: 716-10-5694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Clara Lowery

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Jan. 4 1885

8. AGE: Years	Months	Days	If less than one day
63	3	19	hrs. min.

9. Birthplace: Ellerslie Maryland (Town, county, and state)

10. Usual occupation: P. R.R. Conductor.

11. Industry or business: P.R.R.

FATHER

12. Name: Jacob Bennett

13. Birthplace: Md.

MOTHER

14. Maiden name: Martha Burkett

15. Birthplace: Md.

16. Informant: William Bennett

Address: Washington Dc.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4 (month) 26 (day) 48 (year)

Cemetery or crematory: Palo Alto

Location: Hyndman, Pa.

18. Funeral director: Harvey H. Leigler

Address: Hyndman Pa.

19. 4/24 (Date rec'd by registrar) 19 48 Registrar: Lee Floyd Wolfe

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/23 19 48 at 4.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to Apr 23 19 48 and that I last saw h... alive on 4/23/48 19...

Immediate cause of death	DURATION
Chronic Cardio Vascular Renal Disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Tepper M.D. M. D. or other

Address: Hyndman Pa. Date signed: 4/26/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03404

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 72 Beall St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gertrude Robb Bethman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife John F. Bethman

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Mar. 14 th. 1918

8. AGE:

Years	Months	Days	If less than one day
30	1	10	hrs. min.

9. Birthplace Frostburg Allegany Md. (Town, county, and state)

10. Usual occupation Married Patient

11. Industry or business

FATHER

12. Name Robert L. Easton

13. Birthplace Elk Garden, W. Va.

MOTHER

14. Maiden name Mary E. Crane

15. Birthplace Borden Mines, Md.

16. Informant Mrs. Mary Easton

Address 72 Beall St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26-1948 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director Jacob Yaker

Address Frostburg, Md.

19. 4-27 (Date rec'd by registrar) 1948 A. W. Neidich per Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1948 at 9.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-22 1948, to 4-23 1948 and that I last saw h. P.C. alive on 4-23 1948

Immediate cause of death	DURATION
Heart failure	
Due to pulmonary tuberculosis	
Due to	
Other conditions /	

(Include pregnancy within 3 months of death)

Major findings of operations / Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: /

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adolf Wolfermann M.D. M. D. or other

Address 134 E Main St. Frostburg Date signed 4-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

03405

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Grant

City or town: Bayard

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carol Elaine Broll

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 8, 1947

8. AGE:

Years	Months	Days	If less than one day
0	4	28	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Md.

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Vernon Broll

13. Birthplace: Kempton, W. Va.

MOTHER

14. Maiden name: Gaynelle Mullenax

15. Birthplace: Horton, W. Va.

16. Informant: Mrs. Vernon Broll

Address: Bayard, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 7 1948 (month) (day) (year)

Cemetery or crematory: Carmel Cemetery

Location: Aurora W. Va.

18. Funeral director: John Lutzhoft

Address: Cumberland, Md.

19. April 6, 1948 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 8 1947 to April 6 1948 and that I last saw h... alive on April 6 1948

Immediate cause of death	DURATION
Primary Hydrocephalus	4 mon.
Due to Meningocele	5 mon.
Due to Congenital	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. R. Hodges, M.D.

Address: Cumberland, Md M. D. or other Date signed: 4/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03406

DR. DURRETT

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~DAY~~ 10 yrs

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 PARK ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HORACE BROMLEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife: Emma Simmons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 6 1868

8. AGE: Years 79 | Months 4 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace: Greenville Penn.
(Town, county, and state)

10. Usual occupation: machinist

11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Russel & Riggs

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 19 48 (month) (day) (year)

Cemetery or crematory: Mt Hermon Cem

Location: Rural Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. April 17 1948 (Date rec'd by registrar) Hunter R. Smith M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 15 1948 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1948 to April 15 1948 and that I last saw h.. alive on April 15 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to: Chronic Myocarditis	
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE George M. Lemon M. D. or other

Address Memorial Hosp. Date signed 4/15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

M. E. B. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

03467

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2 - Baltimore Pike.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lois Jean Carder.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1948

8. AGE: Years 0 Months 0 Days 2 If less than one day ... hrs. ... min.

9. Birthplace Cumberland, Allegany Co, Md. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Glenn Carder

13. Birthplace Oldtown, Md.

MOTHER 14. Maiden name Dorothy Boyden

15. Birthplace Cumberland, Md

16. Informant Glenn Carder

Address Rt 2 Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1948 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md

19. May 1 1948 W. R. Trautz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1948 to April 29 1948 and that I last saw h... alive on April 29 1948

Immediate cause of death	DURATION
Premature birth	2 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens M. D. or other

Address 133 Va Ave Date signed 5/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 f

03408

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hours

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Leroy Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Harriett Yost

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 26, 1875

8. AGE:	Years	Months	Days	If less than one day
	72	10	17	..... hrs. ..... min.

9. Birthplace Clark's Mill, Pa.

(Town, county, and state)

10. Usual occupation Pr Railroad Employee

11. Industry or business Retired

FATHER

12. Name John H. Clark

13. Birthplace Pa.

MOTHER

14. Maiden name Mary Clark

15. Birthplace Pa.

16. Informant Mrs. Naomi Snyder

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1948 (month) (day) (year)

Cemetery or crematory Potter Cemetery

Location Hyndman, Pa. R.D.1

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. April 16 19 48 (Date rec'd by registrar) C. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 19 48 to April 13 19 48

and that I last saw h... alive on April 13 19 48

	DURATION
Immediate cause of death Uremia	Unknown
Due to Nephritis, Glomerular Chronic	Unknown
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David Thee Jr M. D. or other

Address Hyndman, Pa. Date signed April 16 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

112

03409

CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs.

Hospital, institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 5 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frost

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. No 2 Frostburg, Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Franklin Clark, Sr

3. (b) Social Security Number 215-10-4387

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Florence Clark

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.): Feb. 12th, 1893

8. AGE: Years 55 | Months 1 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Miner Fireman

11. Industry or business: Coal Mines

FATHER 12. Name: John Clark

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Kitty Kindsvater

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Ed. F. Clark

Address R-D. No. 2 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 11th, 1948 (month) (day) (year)

Cemetery or crematory Lonaconing Cemetery

Location Highway Frostburg, Md.

18. Funeral director: Jacob Kahn

Address Frostburg, Md.

19. 4-10 (Date rec'd by registrar) 1948 W. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1948, at 12:05A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 7 1948 to Apr 8 1948 and that I last saw h[illegible] alive on Apr 7 1948

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	3 hrs
Due to: Bronchial asthma	??
Due to: ? ? ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane M.D. M. D. or other

Address Frostburg Md Date signed 4-9-48

Within corporate limits

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03410

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 55 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 RACE STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. WILLIAM A. CUNNINGHAM

3.(b) Social Security Number 220-10-8733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ELIZABETH JAY CUNNINGHAM 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 13, 1893

8. AGE: Years	Months	Days	If less than one day
55	0	18	hrs. min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation CELANESE CORP OF AMERICA

11. Industry or business Electrician

FATHER
12. Name DANIEL CUNNINGHAM
13. Birthplace MARYLAND

MOTHER
14. Maiden name ROSIE SHETTLE
15. Birthplace MARYLAND

16. Informant Mrs Elizabeth J. Cunningham
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 4 48 (month) (day) (year)

Cemetery or crematory Hillcrest Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 7, 1948 W. P. Beanty M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 1, 19 48 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 19 47 to 4-1- 19 48 and that I last saw h... alive on 3-31- 19 48

Immediate cause of death	DURATION
Chronic Hypocardial Degeneration	
Due to Coronary Arterio-Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M.D. or other

Address Cumberland Date signed 4/11/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

03411

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4/11 to 4/22
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 4/11 to 4/22

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rawlings
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
William Clay Davis
William Davis

3.(b) Social Security Number
220-10-2469

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~LelahBelle Ketterman~~ Mrs. Lelah Davis
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Aug. 18th. ~~1885~~ 1888

8. AGE: Years	Months	Days	If less than one day
~~62~~ 59	8	4	hrs. min.

9. Birthplace: Harmon, W. Va., Tucker County.
(Town, county, and state)
10. Usual occupation: Hazelwood Cont. Co. (Furloughed)
11. Industry or business
FATHER 12. Name: Jesse Davis
13. Birthplace: W.Va.
MOTHER 14. Maiden name: Alice Fairburn
15. Birthplace: W.Va.
16. Informant: Mrs. Lelah B. Davis
Address: Rawlings, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 25, 1948 (month) (day) (year)
Cemetery or crematory: Waxler Cemetery
Location: Danville, Allegany Co. Md.
18. Funeral director: Rogers Funeral Home
Address: Keyser, W. Va.
19. April 23 19 48 W.K. Trautz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 48 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 11 19 48, to april 22 19 48
and that I last saw him alive on april 22 19 48

Immediate cause of death — DURATION

- Uremia — 11 days
- Heart failure — 11 days
Due to - Chronic glomerular nephritis — ?
Due to Hypertensive Heart disease — ?
Pulmonary Heart disease — ?
Other conditions: Pyuria chronic — ~~20~~ ?
Pneumonitis — 20 4
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Orville G. Freeman M.D. M. D. or other
Address: 121 Bedford St. Cumberland Date signed: April 23 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. J. T. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Paul R. Wilson
93c
08113
Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 years
Hospital, institution, or street address where death occurred:
Swanton Hill
How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Swanton Hill
(If rural, give LOCATION)
2.(a) If veteran, name war - - - - -

3.(a) FULL NAME MARY ETTA DAWSON

3.(b) Social Security Number - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Dawson
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): August 6, 1874

8. AGE: Years	Months	Days	If less than one day
73	8	14	..... hrs. ..... min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Own home
FATHER 12. Name: Frederick Kyle
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Harriet Barnes
15. Birthplace: Barton, Maryland
16. Informant: Mrs Buelah Kennel
Address: Frostburg, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23, 1948 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Maryland
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland
19. Apr. 23. 1948 (Date rec'd by registrar) [illegible] MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948, at 4:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1948 to Apr. 20 1948 and that I last saw h[illegible] alive on Apr. 20, 1948

	DURATION
Immediate cause of death: Pulmonary Edema	1 Day
Due to: Myocarditis and Myocardial Degeneration specified as rheumatic	10 Years
Due to:	
Other conditions: other and unspecified forms of chronic rheumatism	10 Years

(Include pregnancy within 3 months of death)
Major findings of operation: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul R Wilson M.D. M. D. or other
Address: Piedmont, W. Va. Date signed 4-22-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119a

03413

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 570 Woodside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Raymond C. Dean.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 1, 1948

8. AGE:

Years	Months	Days	If less than one day
		17	____ hrs. ____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Raymond W. Dean

13. Birthplace Md.

MOTHER 14. Maiden name Eleanor Norris

15. Birthplace Md.

16. Informant Raymond W. Dean

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 19, 1948 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location —

18. Funeral director Louis Stein Inc

Address Cumberland

19 April 19 (Date rec'd by registrar) 18 48 Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948 to April 18 1948 and that I last saw him alive on April 18 1948

Immediate cause of death	DURATION
Acute dilatation	17 days
Due to enteritis	10 days
Due to	
Other conditions premature baby	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE C. Klein M.D. M. D. or other

Address 54 Green St. Date signed 4-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

VANOMER

03414

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Bedford
(If outside city or town limits, write RURAL and give nearest town)

Street No. RT# 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. DAVID Franklin DIEBERT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife MAGGIE, HELSEL

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) MARCH 6, 1867

8. AGE: Years	Months	Days	If less than one day
81	1	22	hrs. min.

9. Birthplace BEDFORD PENNA
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business W.

FATHER 12. Name George DIEBERT

13. Birthplace Bedford County, Penna

MOTHER 14. Maiden name Susannah COBBLER

15. Birthplace Bedford County, Penna

16. Informant D. Marshall Creps (Son-in-law)

Address R.D. 1 PA

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1948 (month) (day) (year)

Cemetery or crematory Pleasant Hill Cem.

Location Imler town Pa

18. Funeral director H. Ed. C. Pat and Son

Address Bedford, Pa.

19. May 1, 1948 (Date rec'd by registrar) W. K. Trauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1948 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1948 to April 28 1948 and that I last saw h. alive on April 28 1948

Immediate cause of death	DURATION
Cardio Vascular Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simmons M. D. or other

Address Memorial Hosp. Date signed 4/28/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

Elizabeth Briggs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03415

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Herman L. Dolan

3.(b) Social Security Number 220-10-2467

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife Pearl Hamilton

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) August 17, ~~1910~~ 1909

8. AGE: Years	Months	Days	If less than one day
38	8	3	..... hrs. ..... min.

9. Birthplace Oldtown Allegany Maryland (Town, county, and state)

10. Usual occupation Mill room employee

11. Industry or business K-S Tire Co.

FATHER

12. Name William A. Dolan

13. Birthplace Twiggtown, Md.

MOTHER

14. Maiden name Virdie Rice

15. Birthplace Allegany Co., Md.

16. Informant Mrs. Lena Owens

Address 528 Woodside Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1948 (month) (day) (year)

Cemetery or crematory Oldtown Cemetery

Location Oldtown, Maryland

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. April 23 1948 (Date rec'd by registrar) Hunter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 20 1948 and that I last saw h... alive on April 19 1948

Immediate cause of death	DURATION
congestive heart failure	
Due to Cardiac insufficiency	
Due to Unknown	
Other conditions Coronary occlusion	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Elizabeth Briggs M. D. or other

Address La Vale, Md. Date signed 4/23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-M5 9-45-15M

E. B-1195

Within corporate limits

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03416

46d

CERTIFICATE OF DEATH

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 E. MAIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Douglas MR. WILLIAM FISHER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife Mrs. Hattie FISHER

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 15, 1872

8. AGE: Years	Months	Days	If less than one day
75	7	5	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation WARDEN AT SYLVAN RETREAT

11. Industry or business

FATHER 12. Name THOMAS FISHER

13. Birthplace SCOTLAND

MOTHER 14. Maiden name MARGARET DOUGLAS

15. Birthplace SCOTLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 48 (month) (day) (year)

Cemetery or crematory Allegany County

Location Frostburg, md

18. Funeral director J. M. Euchhorn

Address Lonaconing, md

19. April 21, 1948 (Date rec'd by registrar) W. R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 20, 1948 at 4:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948 to April 20 1948

and that I last saw h... alive on April 19 1948

	DURATION
Immediate cause of death Toxemia	1 day
Due to Intestinal obstruction, complicated	4 days
Due to Carcinoma rectum	?
Other conditions Grade + type unknown. Not remembered.	

(Include pregnancy within 3 months of death)

Major findings of operations Constricting nodular mass obstructing rectum Date of op. 4-18-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. M. Wilson M. D. or other

Address Cumberland Md Date signed 4-21-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

115C

03417

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8704 Sumitt Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Linda Lee Franks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 27 1943

8. AGE: Years	Months	Days	If less than one day
4	3	13	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: Wylie Franks

13. Birthplace: Cherry Valley, Pa

MOTHER — 14. Maiden name: Janet Dwyer

15. Birthplace: Cumberland, Md.

16. Informant: Mrs Wylie Franks

Address: 8704 Summit Ave, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/12/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 12 1948 (Date rec'd by registrar) W. L. Frantz, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 10 – 1948 at 6.25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 4 – 1948 to Apr 10 – 1948 and that I last saw h.er alive on Apr 10 1948

Immediate cause of death	DURATION
Acute Myocarditis	3 days
Due to Dehydration	
Due to Chr. Virus Infection	
Other conditions Ch. Tonsillitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Ch. Tonsillitis. Date of op. Apr 7-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Leslie E. Daugherty M. D. or other

Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M I T

VS A15 9-45-15M

Within corporate limits of Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03418

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 Hrs.

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Columbia St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Rebecca Lynn Frazier

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Infant

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 25, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	22 hrs. ____ min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Harry Mathis

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Josephine Frazier

15. Birthplace: Cumberland, Md

16. Informant: Allegany Hospital

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1948 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. April 29 1948 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 1948, to Apr 26 1948

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Congenital Syphilis	
Due to Multiple Hematomas	
Due to Hematoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Carl Lewis M.D. or other

Address: Cumberland Date signed 4/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03419

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 402 Beall St.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 402 Beall St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN CHARLES FRICKEY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Katherine Hoffman
Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1864

8. AGE: Years	Months	Days	If less than one day
83	11	24	..... hrs. ..... min.

9. Birthplace: Wheeling, W. Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: William A. Frickey
Address: 402 Beall St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 28, 1948 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 28, 1948 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 1948 at 2:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1948 to April 26 1948 and that I last saw him alive on April 26 1948

Immediate cause of death	DURATION
Chronic myocarditis	
Chronic Nephritis	
Due to	
Due to	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H W Elgeson M.D. M. D. or other
Address: 86 Union St. Date signed: 4/27/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03420

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: Allegany Co Infirmary

How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Peter Gaston

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1883.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
Abt 65				

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business

FATHER — 12. Name: Peter Gaston

13. Birthplace: Greece

MOTHER — 14. Maiden name: Granoula Gaston

15. Birthplace: Greece

16. Informant: Chas. Chaconas

Address: 5208 Colonial Ave NW Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 21 48 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Washington D. C.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. April 20, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Apr 18 1948 and that I last saw h. alive on Apr 16 1948

Immediate cause of death	DURATION
Myocardial failure	6 hrs.
Due to: General debility	4 yrs
Due to: Syphilis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St Date signed 4-19-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

03421

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 810 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 Columbia Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Katherine Anna Goodrich

3.(b) Social Security Number: 220-03-7719

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Solomon Goodrich

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Aug. 17, 1902

8. AGE: Years	Months	Days	If less than one day
45	8	10	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Rompf

13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Nell Rosa Rompf

15. Birthplace: Mt. Savage, Md.

18. Informant: Solomon Goodrich

Address: 810 Columbia Ave., Cumberland,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 30, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 29, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 27, 1948, at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1948, to April 27 1948, and that I last saw h.er alive on April 25 1948.

Immediate cause of death	DURATION
Carcinoma Breast & metastasis to Lungs	1-2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schmidlen M.D. M. D. or other

Address: 41 Greene St. Date signed: April 29, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

T. Bailey Hunter

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03422

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Oldtown - Route 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

Rt. 1, Oldtown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Virginia Grimm

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John W. Grimm

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 28, 1871

8. AGE:

Years	Months	Days	If less than one day
76	5	10	hrs. min.

9. Birthplace: Newburg, Preston Co., W.Va.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER

12. Name: William Wolfe

13. Birthplace: Preston Co., W.Va.

MOTHER

14. Maiden name: Mary Shahan

15. Birthplace: Preston Co., W.Va.

16. Informant: Everett M. Grimm

Address: Rt. 1, Oldtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11, 1948 (month) (day) (year)

Cemetery or crematory: IOOF Cemetery

Location: Newburg, W.Va.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. 4-10-48 19 Mrs. C. A. Shanholtz, Registrar
(Date rec'd by registror)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1948, at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1948 to April 8 1948 and that I last saw h alive on April 7 1948

Immediate cause of death	DURATION
Cardio-Renal disease	
Hypertention	
Due to	
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. Bailey Hunter M.D.
M. D. or other

Address: Cumberland Md. Date signed: 4/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03423

Reg. Dist. No. 14

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Corrigansville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Corrigansville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. GERTRUDE HAMILTON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Samuel Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1875

8. AGE: Years	Months	Days	If less than one day
72	8	18	..... hrs. ..... min.

9. Birthplace Renova Pa.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Kepler

FATHER 13. Birthplace Renova, Pa.

MOTHER 14. Maiden name Susan Rymer

MOTHER 15. Birthplace Renova, Pa.

16. Informant Mrs. Claude Duckworth

Address Corrigansville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24, 1948 (month) (day) (year)

Cemetery or crematory Zion Memorial Burial Park

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. April 24, 1948 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1948 to April 21 1948

and that I last saw her alive on April 21 1948

Immediate cause of death	DURATION
Coronary thrombosis	2 days
Due to Arteriosclerosis	many yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Adam E. Hamm M. D. or other

Address Cumberland Md. Date signed April 23 48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03424

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8Y - 10M - 7D

Hospital, institution, or street address where death occurred:

171 N. Mechanic Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 171 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Genevieve Magdeline Hartung

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Edward H. Hartung

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 26, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	7	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Morton Miller

13. Birthplace Germany

MOTHER 14. Maiden name Magdalena Pfitzenmeier

15. Birthplace Germany

16. Informant Edward Hartung

Address 171 N. Mechanic St. Cumberland Md

17. buried (Burial, cremation, or removal. Which?) Date thereof April 6 1948 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cemetery

Location Cumberland Md

18. Funeral director Louis Klein, Inc.

Address Cumberland Md

19. April 5, 1948 W. L. Fautz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1948 to April 3 1948 and that I last saw h. alive on April 2 1948

Immediate cause of death	DURATION
Chronic myocarditis	several years
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 4-3-/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

Louis Burns 131a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03425

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:
12 Columbia St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town [redacted]
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cresaptown, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Katherine Harvey

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Robt. S. Harvey Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1870

8. AGE: Years	Months	Days	If less than one day
77	6	24	..... hrs. ..... min.

9. Birthplace Streator Ill.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Jardine
13. Birthplace Scotland

MOTHER
14. Maiden name Eliza Finlayson
15. Birthplace Scotland

16. Informant Wm R. Harvey
Address 2802 Cottage St, Huntington W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 13 1948 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director John J. Hafer

Address Cumberland Md

19 April 13, 1948 W. L. Bantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1948 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3rd 1947 to April 11 1948 and that I last saw h... alive on April 9 1948.

	DURATION
Immediate cause of death Uremia	6 days
Due to Chronic hemiplegia resulting from cerebral thrombosis	5 years
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 59 Greene St. Date signed 4-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

De Bering

Within corporate limits

Dr. L. Brinas

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160 C

03426

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Valley View Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Merl Joseph Hivicks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 24, 1948

8. AGE:

Years	Months	Days	If less than one day
		1	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Md

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Merl Hivicks

13. Birthplace: Davis W. Va.

MOTHER

14. Maiden name: Eleanor Shelley

15. Birthplace: Eckhart Mines Md

16. Informant: Merl Hivicks

Address: R 7 5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 26, 1948 (month) (day) (year)

Cemetery or crematory: St Ambrose Catholic Cem

Location: Cresaptown Md.

18. Funeral director: John J Hafer

Address: Cumberland, Md.

19. April 26, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 25 1948, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1948 to April 25 1948 and that I last saw h.. alive on 4-24-48 19..

Immediate cause of death	DURATION
intra cranial hemorrhage	1 day
Due to: rapid delivery	5 Minutes
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L Brinas MD

M. D. or other

Address: 59 Queen St. Date signed: 4-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

546

03427

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 months

Hospital, Institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 13 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Dolsinger

3.(b) Social Security Number 217-10-1522

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Nelson

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 25 - 1893

8. AGE: Years 54 | Months 9 | Days 14 | If less than one day: hrs. min.

9. Birthplace Midland, Allegany, Md. (Town, county and state)

10. Usual occupation Mechanic

11. Industry or business Auto

FATHER 12. Name John Dolsinger

13. Birthplace Unknown

MOTHER 14. Maiden name Jeanne Stark

15. Birthplace Garrett County, Md.

16. Informant Mrs. David Dolsinger

Address Eckhart Mines Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-11-1948 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Dakel

Address Frostburg, Md.

19. 4-10-1948 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 12:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to April 9 1948 and that I last saw him alive on April 8 1948

Immediate cause of death	DURATION
Metastatic Carcinoma of frontal lobe of brain	9 months
Due to (Original lesion not found)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Metastatic Carcinoma of frontal lobe of brain Date of op. 12/26/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jones Walters M.D. M. D. or other

Address Frostburg, Md Date signed 4/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

03428

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No.: — (If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Richard Cornelius Hotchkiss

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Neal

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Apr. 19th - 1880

8. AGE: Years: 68 | Months: 0 | Days: 11 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Fireman & Engineer

11. Industry or business: C. & P. Railroad

FATHER — 12. Name: James Hotchkiss

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Marion Atkinson

MOTHER — 15. Birthplace: England

16. Informant: Mrs. Sara Orndorff

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 1948 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: J. M. Eichhorn

Address: Lonaconing, Md.

19. April 2nd 1948 W. H. Frantz, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1948, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1948 to April 30 1948 and that I last saw h— alive on April 29 1948

Immediate cause of death	DURATION
Encephalitis acute	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Allan G. Munn, M. D. or other

Address: Cumberland, Md. Date signed April 30 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 | b

03429

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-25-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred: Meyers Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles James Hughes

3.(b) Social Security Number: 213-01-4666

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary M. Hughes

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): November 20, 1897

8. AGE: Years: 50 Months: 4 Days: 18 If less than one day: ....hrs. ....min.

9. Birthplace: Mt. Savage Allegany Md.

(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: Coal mines

FATHER

12. Name: William Hughes

13. Birthplace: unknown

MOTHER

14. Maiden name: Christa Jane Rice

15. Birthplace: unknown

16. Informant: Mrs. Myrle Witt

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 10 1948 (month) (day) (year)

Cemetery or crematory: St. George's Cemetery

Location: Mt. Savage Md.

18. Funeral director: J. C. Durst

Address: Frostburg Md.

19. 4-10 (Date rec'd by registror) 1948 Mrs. Daisy V. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 7 19.48 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 7 19.48 to Apr 7 19.48

and that I last saw him alive on Apr 7 19.48

Immediate cause of death	DURATION
Cerebral Oedema	24 hrs
Due to: Uk. Nephritis	? ?
Due to:	
Other conditions:	

(Include pregnency within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. McLane M.D. M. D. or other

Address: Frostburg Md Date signed: 4-9-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03430

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Emily Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES J. KABOSKY

3.(b) Social Security Number: 215 20 5552

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1929

8. AGE: Years	Months	Days	If less than one day
18	10	6	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland

(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Sanitary Market, Cumberland, Md.

FATHER

12. Name: Thomas Kaboskey

13. Birthplace: Cumberland, Md,

MOTHER

14. Maiden name: Marion Fazenbaker

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Marion Weimer

Address: 323 Emily St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30, 1948 (month) (day) (year)

Cemetery or crematory: St. Peter and Pauls Cemetery

Location: Cumberland, Maryland

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 29, 1948 (Date rec'd by registrar) W. K. Trauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1948 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1948 to April 28 1948

and that I last saw h[illegible] alive on April 27 1948

Immediate cause of death: Massive Hemorrhage of Hemorrhage

Massive

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: 4-28-48

Within corporate limits

DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

-03431

Reg. Diat. No. 4

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 HRS & 15 min

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 8 hrs 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. RT# 6, PARK HEIGHTS
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MRS. FLORA MAY KALBAUGH

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	widowed

6.(b) Name of husband or wife GEORGE KALBAUGH

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	19	hrs. min.

9. Birthplace WEST VIRGINIA Harrisville
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Elmore PATTON
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name JANE WOOD
15. Birthplace WEST VIRGINIA

16. Informant M. Albert Kalbaugh
Address Rt#6 Park Heights, Cumberland, Md.

17. Burial Date thereof 5/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cem.

Location Westernport, Md.

18. Funeral director H. Wayne George
Address Cumberland, Md.

19. May 1 1948 Wister R. Beatty M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 29, 1948 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1, 1948 to Apr. 29, 1948 and that I last saw her alive on Apr. 29, 1948

Immediate cause of death	DURATION
Coronary Thrombosis	3 mon.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay R. Lemmon M.D. or Other

Address Cumberland Date signed 4/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-25-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03432

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. MIRKIN

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MONTHS 4 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 MONTHS 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: Res CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RT. # 6
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MRS. MARTHA KALBAUGH

3. (b) Social Security Number: NOne

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: ALBERT KALBAUGH
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 7, 1911

8. AGE: Years	Months	Days	If less than one day
36	5	19	..... hrs. ..... min.

9. Birthplace: MARYLAND, Cumberland (Town, county, and state)
10. Usual occupation: REGISTERED NURSE and Housewife
11. Industry or business:

FATHER
12. Name: CHARLES WRIGHT
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: GEORGIA MOWER
15. Birthplace: Penna.

16. Informant: M. Albert Kalbaugh
Address: Rt.#6 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 29, 1948 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. April 29 19 48 W. L. Trautz, M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 26 19 48 at 1:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to 4-26 19 48
and that I last saw h... alive on 4-24 19 48

Immediate cause of death	DURATION
Metastatic carcinoma to spine, scapula, humerus, lungs	3-4 mo.
Due to: Adenocarcinoma of breast	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma of breast, left Date of op. June 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. J. Mirkin M.D.
M. D. or other
Address: 115 S Centre St Date signed: 4-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

03433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 Yrs 8 Mo 8 Days
Hospital, Institution, or street address where death occurred:
213 Saratoga St
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 213 Saratoga St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna Kelly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm J. Kelly
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 29 1884

8. AGE: Years	Months	Days	If less than one day
62	8	8	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: John Hodel
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Alice Morgan
15. Birthplace: Hagerstown Md

16. Informant: William J. Kelly
Address: 213 Saratoga St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 10, 1948 (month) (day) (year)
Cemetery or crematory: St Peter & Paul Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. April 9 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 47 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac Thromb.	mos
Due to Arteriosclerosis	yrs
Due to Diabetes Mellitus	
Other conditions Agony Uremia C.V. Renal Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 46 Decatur St Date signed: 4/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

Within corporate limits

03434

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Maggie Kevalaitis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Kevalaitis

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): March 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	0	17	...hrs. ...min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: Antonia Veivrus

FATHER — 13. Birthplace: Lithuania

MOTHER — 14. Maiden name: Dont Know

MOTHER — 15. Birthplace:

16. Informant: George Kevalaitis

Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5, 1948 (month) (day) (year)

Cemetery or crematory: Kalbaugh Cemetery

Location: Elk Garden, W.Va.

18. Funeral director: Otha F. Sharpless

Address: Blaine, W.Va.

19. April 5 1948 (Date rec'd by registrar) W. R. Tracey, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 48, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948, to April 3 1948 and that I last saw h.. alive on April 2 1948

Immediate cause of death: Apoplexia — DURATION: 3 days ?

Due to: Pre-renal failure — 3 days ?

Due to: Hypertensive and Arteriosclerotic cardio-renal-vascular disease — 10 yrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David G. Wessman M.D.
M. D. or other

Address: 122 Bedford St., Cumberland Date signed: April 3, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03435

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 214 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 214 E. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Krauss

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): (Unknown) 1873

8. AGE: Years: 75 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Home

11. Industry or business:

FATHER — 12. Name: Henry L. Krauss

13. Birthplace: Germany

MOTHER — 14. Maiden name: Martha Lefsmert

15. Birthplace: Maryland

16. Informant: Miss Laura Krauss

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 17, 1948 (month) (day) (year)

Cemetery or crematory: Bon Ease + Ref. Cemetery

Location: Frostburg, Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 4-16 1948 Mrs Bailey N. Roe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1948 at almost 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive April 16 1948 and that death occurred at the time and date above stated.

	DURATION
Immediate cause of death: Coronary occlusion	10 min
Due to: Arteriosclerosis	about 1 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: Herbert V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed 4-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03436

Reg. Dist. No. 4

Dr Richard Mary

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS. A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Edward Kuhn

3.(b) Social Security Number 714-05-7343A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Flora Brightwell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 23 1882

8. AGE: Years	Months	Days	If less than one day
65	3	20	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Wholesale meats

FATHER 12. Name Mason Crabtree

13. Birthplace Md

MOTHER 14. Maiden name Ruth Twigg

15. Birthplace Md

16. Informant Ruth Kuhn

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 15 48 (month) (day) (year)

Cemetery or crematory Mt. Tabor Cem.

Location Rural Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 15 19 48 Hunter R. Scott M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 5 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3/47 19.. to 4/13/48 19.. and that I last saw h.. alive on 4/12/48 19..

	DURATION
Immediate cause of death Uremia	1 month
Due to Chr. Myocarditis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Enlarged Heart, granular Kidneys

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. H. Williams, M.D. M.D. or other

Address Med. Bldg. Cumb. Md. Date signed 4/14/48

Dr. Richard Williams

217 Brownell St.
Pitts 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

03437

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Thomas Lancaster

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary E. Laney

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1862

8. AGE: Years	Months	Days	If less than one day
86	0	22	hrs. min.

9. Birthplace Eckhart Allegany Md. (Town, county, and state)

10. Usual occupation Retired Engineer

11. Industry or business Coal Mines

FATHER 12. Name Robert Lancaster

13. Birthplace Unknown

MOTHER 14. Maiden name Mary Cross

15. Birthplace Unknown

16. Informant Brother Lancaster

Address Eckhart, Md.

17. Burial Date thereof 4-22-1948 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart Md.

18. Funeral director Jacob Davis

Address Frostburg Md.

19. 4-20 1948 Mrs. Nancy V. Rice (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1948 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/19 1948

and that I last saw h. alive on 4/19 1948

Immediate cause of death	DURATION
Arteriosclerotic Heart disease & genitial arterios. sclerosis	20 yrs.
Due to Post-op. supra-pubic cystotomy	3 mos.
Due to	
Other conditions Benign Hypertrophy of Prostate	6 mos +

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Frank T. Harrat M.D. M. D. or other

Address 52 E. Main St., Frostburg Md. Date signed 4/20/48

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03438

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2 years
Hospital, institution, or street address where death occurred: Windsor Hotel, 154 Baltimore St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 154 Baltimore St. Windsor Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roland E. Leach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30- 1909

8. AGE: Years	Months	Days	If less than one day
38	8	25	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Workshop for the blind.
FATHER 12. Name James Leach
13. Birthplace Md.
MOTHER 14. Maiden name Martha Sprinkle
15. Birthplace Md.
16. Informant James Leach
Address 2705 Chelsea Terrace, Baltimore Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1948 (month) (day) (year)
Cemetery or crematory Mt. Zion Hartford Co. Md.
Location Near Freeland Maryland
18. Funeral director John C. Ford
Address 129 S Liberty St.
19. April 26 1948 (Date rec'd by registrar) Wm. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1948 at about 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead April 25 1948

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to coronary sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.
23. SIGNATURE H. V. Deming M.D. H. V. Deming M. D.
Address Cumberland Md. Date signed 4-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

03439

Reg. Dist. No. 1 4

1. PLACE OF DEATH:

County Allegany

City or town R.F.D.1 -Old Town Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
R.F.D #1 Box 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town R.F.D.1- Old Town Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 1 Box 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ruth Leasure

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Daniel Leasure

6.(c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) Sept. 25- 1871

8. AGE: Years	Months	Days	If less than one day
76	6	16	hrs. min.

9. Birthplace Old Town Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business AT HOME

FATHER 12. Name Lawrence O. Piper

13. Birthplace Md.

MOTHER 14. Maiden name King

15. Birthplace Md.

16. Informant Daniel Leasure

Address R.D. #1 Oldtown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 13 48 (month) (day) (year)

Cemetery or crematory Davis Memorial Cem

Location Rural Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 13 1948 (Date rec'd by registrar) Mrs C.A. Trunkett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive Dead April 11 1948

Immediate cause of death	DURATION
Chronic Endocarditis	several years
Due to Rheumatoid arthritis	8 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 4-11-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03440

47d

Reg. Dist. No. 9

M

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VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

164 Ormond St.

How long in hospital or institution? Op. time

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 Ormond St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Selma Russell Lehr

3. (b) Social Security Number 214-05-4577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife Selma Lehr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10 - 1882

8. AGE: Years 65 | Months 6 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Zihlman, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Queen City Milk Co.

FATHER 12. Name Chas. Russell Lehr

13. Birthplace Selma, Md.

MOTHER 14. Maiden name Ellen Washburn

15. Birthplace Mt. Savage, Md.

16. Informant Mrs. Lee Emerson

Address 164 Ormond St. Frostburg Md.

17. Burial Date thereof 4-5-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Bafile

Address Frostburg, Md.

19. 4-3 1948 Mrs. Harry H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..... to — 19.....

and that I last saw h.. alive on 12-2 1947

Immediate cause of death	DURATION
Hemostasis	1 hr
Hemothorax from uncovered incision	
Due to Post op. exploratory operation	
for Carcinoma of lung	11 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of R lung

Date of op. March 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank I. Harrat M.D.
M. D. or other

Address 59 E. Main St., Frostburg, Md. Date signed 4/2/48

Within corporate limits. DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03441

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ½ hour

Hospital, Institution, or street address where death occured:

Memorial Hospital

How long in hospital or Institution? ½ hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veleran, name war

3. (a) FULL NAME Ida Alzine Lewis

3. (b) Social Security Number none

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theoplus Lewis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 22, 1869

8. AGE: Years: 78 | Months: 8 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mt. Savage Allegany, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Cornelius Geary

13. Birthplace: Maryland

MOTHER

14. Maiden name: Elizabeth Boland

15. Birthplace: Maryland

16. Informant: Myrtle Lewis

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-48 (month) (day) (year)

Cemetery or crematory: M.E. cemetery

Location: Mt. Savage, Md.

18. Funeral director: J. R. Hurst

Address: Frostburg Md

19. May 1, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 29, 19 48 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29 19 48 to 4-29 19 48

and that I last saw h alive on 4-29 19 48

Immediate cause of death	DURATION
Cerebral	
Due to: Hemorrhage	3
Due to:	1 hr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 4-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Reed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03442

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

204 Humbird St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Humbird St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr John Christian Lewis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Adelia E. Stewart

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1864

8. AGE: Years	Months	Days	If less than one day
83	8	17	hrs. min.

9. Birthplace Independence, Preston Co., W. Va.

(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business B. & O. Railroad

FATHER 12. Name Christian Lewis

13. Birthplace Terra Alta W. Va.

MOTHER 14. Maiden name Sucretia Warthen

15. Birthplace Grafton W. Va.

16. Informant Chauncey Lewis

Address 204 Humbird St Cumb. Md

17. Burial Date thereof Apr. 14, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. April 14, 1948 Hunter R. Trinty, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 10 1948

and that I last saw him alive on April 10 1948

	DURATION
Immediate cause of death Myocardial Insufficiency	1 Mon
Due to Intern Sclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Rees M. D. or other

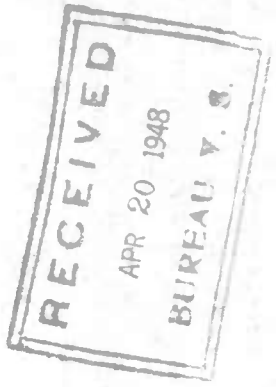
Address 204 Decatur St Date signed 4/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Please call 65
when signed.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

U3443

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days.

Hospital, Institution, or street address where death occurred: 377 Pennsylvania Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 377 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Christine Jane Linaburg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband: George Jr. Linaburg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 1871

8. AGE: Years: 76 Months: 10 Days: 29 If less than one day: ..... hrs. ..... min.

9. Birthplace: Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER — 12. Name: Bertram Twigg

13. Birthplace: Md.

MOTHER — 14. Maiden name: Savilla ——

15. Birthplace: Md.

16. Informant: Julian Linaburg

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 10 '48 (month) (day) (year)

Cemetery or crematory: Davis Memorial Cem.

Location: Cumberland

18. Funeral director: Louis Stein Sons.

Address: Cumberland.

19. April 9, 1948 (Date rec'd by registrar) W. R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1948 at 7 30/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febr. 5 1946 to April 8 1948 and that I last saw her alive on April 7 1948

Immediate cause of death: Cerebral Sclerosis — DURATION: 10 d.

Due to:

Due to:

Other conditions: Diverticulitis of colon

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. Bruns, M.D. M. D. or other

Address: La Vale, Md. Date signed: 4/8/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b

03444

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 133 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JAMES V. MCGREEVY

3.(b) Social Security Number 220-10-0487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1897

8. AGE: Years	Months	Days	If less than one day
50	5	19	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Riverside Lunch (Part time)

11. Industry or business

FATHER 12. Name Michael McGreevy

13. Birthplace Ireland

MOTHER 14. Maiden name Anna Footen

15. Birthplace Maryladn.

16. Informant Memorial Hospital

Address Cumberland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 20-48 (month) (day) (year)

Cemetery or crematory Rhodes Cemetery

Location Westernport, Md.

18. Funeral director W. Harold Frederick

Address Piedmont, W. Va.

19 April 20 19 48 W. L. Lantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948 19 48 at 9:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 March 19 48 to 18 April 19 48 and that I last saw him alive on 18 April 19 48

Immediate cause of death	DURATION
Cardiac failure	
Due to Carbuncle Fever	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simons M. D. or other

Address Memorial Hospital Date signed 18 April 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Rural) near Old Town Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Rural) near Old Town Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Gordon Mc.Millan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 14- 1947

8. AGE: Years: 0 Months: 4 Days: 11 If less than one day: hrs. min.

9. Birthplace: near Old Town Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER 12. Name: David Mc Millan
13. Birthplace: Lonaconing Md.

MOTHER 14. Maiden name: Nellie I. Myers
15. Birthplace: Cumberland Md.

16. Informant: David S. Mc Millan
Address: R.F.R.1 Old Town Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 27 1948 (month) (day) (year)
Cemetery or crematory: St. Lukes
Location: Cumberland Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. April 27 1948 (Date rec'd by registrar) Mrs. L. A. Stonebolt Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1948 at 7.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead April 25 1948

Immediate cause of death: Tracheal bronchitis, bronchial obstruction — DURATION: at once
Due to: mucus plugs in bronchi
Due to:
Other conditions: Had bronchial pneumonia 3-13-48 to 3-23-48
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H.V. Deming M.D.
M. D. or other
Address: Cumberland Md. Date signed: 4-26-48

Within corporate limits

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157d

03446

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNSYLVANIA County Bedford

City or town EVERETT
(If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE # 3
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME
MRS. MARY J. MEARKLE

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife MR. COY E. MEARKLE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 26, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	26	..... hrs. ..... min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation TEACHER AT FLETCHER SCHOOL

11. Industry or business

FATHER
12. Name ABRAHAM MILLER
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name ALVINA HICKSON
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE., CITY

17. Burial Date thereof April 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockhill Cem

Location Nr Everett Pennsa

18. Funeral director Chas P Balentine

Address Everett, Pa

19. April 23, 1948 W.R. Fauntz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22, 1948 at 2:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-19-1948 to 4-22-1948 and that I last saw her alive on 4-21-1948

Immediate cause of death	DURATION
Congenital Cerebral Lues	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results See cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W.F. Williams M. D. or other

Address Cumberland Date signed 4-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

03447

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

199 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 199 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Susanna Mensbach

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: John Mensbach

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 2 1869

8. AGE: Years	Months	Days	If less than one day
79	2	23	5 hrs. — min.

9. Birthplace (town, county, and state): Crosaptown - Alleg - Md.

10. Usual occupation: house wife

11. Industry or business

FATHER

12. Name: Frank Alexander

13. Birthplace: Cresaptown, Md.

MOTHER

14. Maiden name: Catherine

15. Birthplace: Cresaptown, Md.

16. Informant: Albert Mensbach

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-1948 (month) (day) (year)

Cemetery or crematory

Location: Zion Evangelical - Frostburg

18. Funeral director: J. J. Durst

Address: Frostburg

19. 4-17 1948 (Date rec'd by registrar) Mrs. Nancy A. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1948 at 12 00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 14 1948, to April 13 1948 and that I last saw h alive on April 13 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION: 15 hr

Due to: Arterio Sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane M.D. M. D. or other

Address: Frostburg Md. Date signed 4-16-48

M

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

03448

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70-6-23

Hospital, institution, or street address where death occurred: 627 Oldtown Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No 627 Oldtown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Laura Moran.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Michael P Moran

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1877

8. AGE:

Years	Months	Days	If less than one day
70	6	23	hrs. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name Martin Wempe

13. Birthplace Cumberland Md

MOTHER 14. Maiden name Margaret McDonald

15. Birthplace Martinsburg W. Va

16. Informant Michael P Moran

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10 '48 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. April 9 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 6. 1948 to Apr. 6. 1948 and that I last saw h[illegible] alive on Apr. 6. 1948

Immediate cause of death	DURATION
Cardiac asthma	20 min
Due to Coronary Sclerosis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Date signed 4/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH Dr Reeves 03449
2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME LULA MOWBRAY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Mowbray
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): September 21, 1893

8. AGE: Years	Months	Days	If less than one day
54	7	3	hrs. min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Own home

FATHER
12. Name: Samuel Brooks
13. Birthplace: Barton, Md

MOTHER
14. Maiden name: Isabella Moore
15. Birthplace: Barton, Maryland

16. Informant: Forrest Mowbray
Address: Barton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1948 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Md,

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19 Apr. 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1948 19 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1948 to April 27 1948 and that I last saw h alive on April 20 1948

Immediate cause of death	DURATION
Diabetes mellitus	1 yr.
Due to: Diseased teeth & gums	1 yr.
Due to: Cirrhosis of liver	6 mos
Due to: Diabetic retinitis	6 mos
Other conditions: Anasarca	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Norman Reeves M. D. or other
Address: Westernport Md Date signed: 4/26/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

124 b

03450

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 192 Wineow St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1.

3. (a) FULL NAME: David Arnold Murphy

3. (b) Social Security Number: 212-18-1169

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Myrtle Hodel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	23	hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Restaurant

FATHER 12. Name: Charles Murphy

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Crawfis

15. Birthplace: Maryland

16. Informant: Mrs. Myrtle Cage

Address: 117 5th St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19, 1948 (month) (day) (year)

Cemetery or crematory: S.S. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 18, 1948 (Date rec'd by registrar) C.K. Fauth M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1948, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1948 to Apr. 16 19..

and that I last saw h... alive on Apr. 16 19..48

Immediate cause of death: Cirrhosis Liver — DURATION: Approx 2 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: Apr 18 19..

Dr. Reese

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52

03451

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 Yrs 10 Mo 10 Days

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or Institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. 3.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Wilson Neff

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie Zembower Neff

6.(c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.): May 30 1873

8. AGE: Years	Months	Days	If less than one day
74	10	10	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER
12. Name: J. W. Neff
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria Wilson
15. Birthplace: Penna

16. Informant: J Wilson Neff
Address: Rt. 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 12 1948 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 12 1948 (Date rec'd by registrar) Carl Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1948 at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948 to April 10 1948

and that I last saw h... alive on ... 19...

Immediate cause of death: Carcinoma of Bladder — DURATION: 3 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: Carcinoma bladder and bowel

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. J. Johnson M.D.
M. D., or other

Address: Cumberland Md. Date Signed 4-11-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

03452

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Marion St.

How long in hospital or institution? Allegany Hospital. D.O.A Dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 475 Baltimore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Paul Nelson

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3- 1942

8. AGE: Years	Months	Days	If less than one day
5	9	6	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Orville Nelson

13. Birthplace: Cumberland Md.

MOTHER 14. Maiden name: Alma Taylor

15. Birthplace: Pittsburg Pa.

16. Informant: Orville Nelson

Address: 475 Baltimore Ave. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/12/48 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 12 19 48 (Date rec'd by registrar) W.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 19 48 at about 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive April 9 19 48

Immediate cause of death: Intracrainal hemorrhage due to a basal fracture of the skull & severe concussion of the brain. — DURATION: at once

Due to: being hit by an automobile

Other conditions: Fractures of the 3rd, 4th & 5th. ribs right side of chest Fracture of left femur.
(Exclude pregnancy within three months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 4-9-48

Where did injury occur? Marion St. Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Marion St.

Means of injury: on scooter, ran in front of an auto. Injured at work?

~~Deputy Medical Examiner - Allegany Co.~~

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 4-9-48

Within corporate limits

Elinson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 b

03453

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, Institution, or street address where death occurred:

911 Lexington Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 911 Lexington Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George William Nield.

3. (b) Social Security Number: 705-07-6631

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Bessie A. Fauble

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1875

8. AGE: Years	Months	Days	If less than one day
72	9	11	..... hrs. ..... min.

9. Birthplace: Millstone Point, Washington Co., Md.
(Town, county, and state)

10. Usual occupation: Retired Engineer

11. Industry or business: B & O R. R.

FATHER
12. Name: Joseph E. Nield
13. Birthplace: Md.

MOTHER
14. Maiden name: Rachel Snyder
15. Birthplace: Md.

16. Informant: Miss Loretta Nield

Address: 911 Lexington Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. April 24, 1948 (Date rec'd by registrar) W. L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947 to April 22, 1948 and that I last saw h.. alive on April 21, 1948

Immediate cause of death: Carcinoma of Stomach — DURATION: 10 Mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. W. Eleazer M.D.

Address: 126 Queen St. Cumberland Md. Date signed: 4/23/48

M.D. or other

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03454

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74-9-25

Hospital, institution, or street address where death occurred: 104 Thomas St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Thomas St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Edward Riland

3.(b) Social Security Number 705-10-8573

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Lillian Johnson

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 6 1873

8. AGE: Years 74 | Months 9 | Days 25 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Stationary Engineer.

11. Industry or business Hotel.

FATHER 12. Name Matthias A. Riland

13. Birthplace Ireland.

MOTHER 14. Maiden name Sarah Welch.

15. Birthplace Ireland.

16. Informant Mrs. Edna E. Riland

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 5 '48 (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland.

18. Funeral director Long Stein Dale

Address Cumberland

19. April 3, 1948 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 at 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/15/48 19 to 4/1/48 19

and that I last saw h alive on 4/1/48 19

Immediate cause of death	DURATION
Myocardial Infarction Chr.	6 mo
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Lantz M.D. M. D. or other

Address 104 Thomas St. Cumberland Date signed 4/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Richard Stallings

Within corporate limits

W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03455

46d

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State West Virginia County Grant
City or town Petersburg (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HENRIETTA OURS

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: George E. Ours
6.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) October 23, 1886

8. AGE: Years 61 | Months 5 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Arch Crites
13. Birthplace W. Va.

MOTHER
14. Maiden name Weiss, Cecelia
15. Birthplace W. V.

16. Informant Memorial Hospital
Address Cumberland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1948 (month) (day) (year)
Cemetery or crematory Templeville Cem.
Location Templeville, Md.

18. Funeral director J. E. Thrush & Son by Karl Bush F.D.
Address Petersburg W. Va.

19. April 5, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948, at 8:48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1948 to April 4, 1948 and that I last saw her alive on April 4, 1948

Immediate cause of death: Obstructing Carcinoma Sigmoid. DURATION

Due to: Mikulicz Operation

Due to: Acute Hepatitis[illegible] 108 Follow[illegible]

Other conditions: Operation (Include pregnancy within 3 months of death)

Major findings of operations: Tumor Lower Sigmoid Adherent Abdominal Wall date of 4-1-48

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE A H Hawkins M.D. or other
Address ... Date signed 4-5-48

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

03456

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hosp.
How long in hospital or institution? 2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 600 Laing Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DOUGLAS D. PARKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beatrice Hansrote
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1888

8. AGE: Years	Months	Days	If less than one day
60	0	2	..... hrs. ..... min.

9. Birthplace: Martinsburg, W. Va.
(Town, county, and state)
10. Usual occupation: Retired Carman
11. Industry or business: B. & O. Railroad

FATHER
12. Name: Arch S. Parker
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Caroline Dugan
15. Birthplace: W. Va.

16. Informant: Mrs. Beatrice Parker
Address: 600 Laing Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 16, 1948 (month) (day) (year)
Cemetery or crematory: Mt. Herman
Location: Near Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 15 19 48 Vinton R. Beantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 19 48 at 5:10 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 12 19 48 to April 12 19 48
and that I last saw h... alive on April 12 19 48

Immediate cause of death: Aneurysm of Abdominal aorta,

	DURATION
Due to	3 hours,
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Aneurysm of abdominal aorta
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: B. M. Schindler M.D.
M. D. or other
Address: 41 Emerson, Date signed: April 14, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03457

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 SPRUCE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PILLON, ROSE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: PILLON, PAUL PHILLIP
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/18/1879

8. AGE: Years	Months	Days	If less than one day
69	0	4	hrs. min.

9. Birthplace: W. VA. Parkersburg
(Town, county, and state)
10. Usual occupation: HWFE
11. Industry or business:

FATHER
12. Name: WILCOX GEORGE
13. Birthplace: OHIO

MOTHER
14. Maiden name: Coulters, ELIZABETH
15. Birthplace: OHIO

16. Informant: Mrs. Hazel Hartsock
Address: 219 S. Spruce St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 25, 1948 (month) (day) (year)
Cemetery or crematory: Mt. Herman
Location: Near Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 24, 1948 (Date rec'd by registrar) Wm. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/22/48, 1948, at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/12, 1948, to 4/22, 1948, and that I last saw h[illegible] alive on 4/22/48, 1948.

Immediate cause of death	DURATION
Myocardial Infarction	
Due to Myocardial degeneration	
Due to Congestive failure	
Other conditions Bronchopneumonia (atypical)	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George M. Simons, M. D. or other
Address: Memorial Hosp. Date signed: 4/22/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

Dr Davis
03458

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address, where death occurred:

Miners Hospital

How long in hospital or Institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Route 1 Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Albert Plummer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude R. Plummer

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): April 1, 1871

8. AGE: Years: 77 | Months: 6 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Midlothian, Allegany Md.
(Town, county, and state)

10. Usual occupation: Retired carpenter

11. Industry or business: Coal mines

FATHER 12. Name: George Plummer

13. Birthplace: Maryland

MOTHER 14. Maiden name: Primstine

15. Birthplace: unknown

16. Informant: Miss Ivy Plummer

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 15 1948 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 4-15 (Date rec'd by registrar) 1948 Mrs Nancy N. Rue Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 April 48 1948 at 5 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 apr. 48 1948 to 13 April 1948 and that I last saw him alive on 13 april 1948

Immediate cause of death: Pulmonary edema - Sever

DURATION

Due to: Congestive Heart Failure

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John B. Davis, M.D.

M. D. ~~or other~~

Address: Frostburg, Md. Date signed: 13 April 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

0345 Zone

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address (where death occurred) 33 Water St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Water St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Rosabella Powell

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas Powell
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) November 20, 1869

8. AGE:

Years	Months	Days	If less than one day
78	4	29	____ hrs. ____ min.

9. Birthplace Frostburg Allegany Md.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business home
FATHER 12. Name Joseph Dennison
13. Birthplace Maryland
MOTHER 14. Maiden name Sydney Dawson
15. Birthplace Maryland
16. Informant Thomas Powell
Address Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 22 1948 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director J. E. Durst
Address Frostburg Md
19. 4-21 1948 Mrs. Mary K. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19__ to Apr. 19 1948
and that I last saw her alive on Apr. 13 1948

	DURATION
Immediate cause of death Pernicious Anaemia	3 yrs
Due to Chr. Myocarditis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W M McLane MD
M. D. or other
Address Frostburg Md Date signed 4-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 03460

Reg. Dist. No. 1

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County Allegany
City or town Rural - Belle Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME JOHN PURNELL.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	W	WIDOWED.

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 4 1859

8. AGE: Years	Months	Days	If less than one day
88	9	22	...hrs. ...min.

9. Birthplace MILLSTONE WASH. Co. MD.
(Town, county, and state)

10. Usual occupation LABORER.

11. Industry or business —

FATHER
12. Name FREDERICK PURNELL.
13. Birthplace WASH. CO. MD.

MOTHER
14. Maiden name MATILDA MANNING.
15. Birthplace WASH. CO. MD.

16. Informant JOHN PURNELL.
Address Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 28 1948 (month) (day) (year)
Cemetery or crematory Cedar Grove Christian
Location near Warfordsburg, Penna.

18. Funeral director Charles R. Bast
Address Hancock, Md.

19. April 27 1948 (Date rec'd by registrar) Mrs. J. A. Watson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1948, at 7 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1948 to April 26 1948 and that I last saw him alive on April 25 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE J. A. Watson M.D.
M. D. or other
Address Little Orleans Md. Date signed 4/27/48

Within corporate limits

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1 a

03461

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town [redacted] MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. [redacted] Mountain
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME THOMAS REED

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife MARTHA JONES
6.(c) If alive, give age [redacted] years
7. Birth date of deceased (mo., day, yr.) JUNE 2, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	11	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name THOMAS REED
13. Birthplace WALES

MOTHER
14. Maiden name MARTHA JONES
15. Birthplace WALES

16. Informant WAYNE REED
Address 320 MARYLAND AVE., WESTERNPORT, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4/16/48 (month) (day) (year)
Cemetery or crematory ALLEGANY CEMETERY
Location FROSTBURG, MARYLAND
18. Funeral director JACOB HAFER
Address FROSTBURG, MARYLAND

19. April 16 19 48 (Date rec'd by registrar) Hunter R. Darby M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 13, 1948, at 6:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Apr. 13 1948
and that I last saw h. alive on Apr 12 1948

Immediate cause of death	DURATION
Uremic Poisoning	10 days
Due to Chronic nephritis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other
Address 110 S. Centre St Date signed 4-16-48

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

03462

Reg. Dist. No. 4

DR. WHITWORTH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town [redacted] Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. 4 FURNACE ST., [redacted] (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BABY BOY SCINTA

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	NB

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 31 1948

8. AGE: Years ~~1 day~~ | Months | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace MD (Town, county, and state) Cumberland Allegany Co., Md.

10. Usual occupation

11. Industry or business

FATHER 12. Name ~~HARRY ROSS~~ ANTHONY SCINTA

13. Birthplace MARYLAND

MOTHER 14. Maiden name [redacted] Agnes Donald

15. Birthplace MARYLAND

16. Informant Hospital records

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1948 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, Md.

18. Funeral director Edward A Beal

Address Westernport Md.

19. April 3 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948, to April 1 1948

and that I last saw h~~e~~r alive on April 1 1948

Immediate cause of death	DURATION
Atelectasis	
Due to	
Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simmons M. D. or other

Address Memorial Hosp. Date signed

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Have Miss Adams get this signed & send to health dept.

NAME OF WIFE changed by letter from Dr.Owens filmed G115 5-10-48 LL

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03463

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, Institution, or street address where death occurred:
23 5th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 5th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: AMOS E. SEE

3.(b) Social Security Number: 705-10-0063

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: ~~Susan V. See~~ ELIZABETH H. SEE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1870

8. AGE: Years	Months	Days	If less than one day
78	2	16	..... hrs. ..... min.

9. Birthplace Peru Hardy Co. W. Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business B. & O. R. R.

FATHER
12. Name James See
13. Birthplace Peru, W. Va.

MOTHER
14. Maiden name Pricilla See
15. Birthplace Peru, W. Va.

16. Informant Mr. Charles See
Address 509 Maryland Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25, 1948 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumb rland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. April 24, 1948 (Date rec'd by registrar) W.R. Fraunfelter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at 8 35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948 to April 21 1948 and that I last saw him alive on April 21 1948

	DURATION
Immediate cause of death Chronic Myocarditis	7 Days
Due to Arterio Sclerosis	2 Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury ..... Injured at work?

23. SIGNATURE M E B Owens M. D. or other
Address 133 Va ave Date signed 4/22/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03464

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

T

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Dawsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rd 220

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Delilah Ann Shaffer

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Wm Shaffer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 27 1867

8. AGE: Years: 85 Months: 10 Days: 23 If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkins W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace:

MOTHER 14. Maiden name:

15. Birthplace:

16. Informant: Samuel Shaffer

Address: Dawsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 18 48 (month) (day) (year)

Cemetery or crematory: Bruceton Cem.

Location: Bier, Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. April 17 1948 (Date rec'd by registrar) Carl Fautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1946 to April 15 1948 and that I last saw h... alive on April 15 1948

	DURATION
Immediate cause of death: acute coronary occlusion	4 hours
Due to: arteriosclerosis	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas Mills M.D. M. D. or other

Address: 59 Green St. Date signed 4-18-48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

127 b

03465

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegheny
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks
Hospital, Institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Wilbert Shaffer

3.(b) Social Security Number: 216-18-1434

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Helen Morgan
6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): May 8, 1924

8. AGE: Years	Months	Days	If less than one day
23	11	0	hrs. min.

9. Birthplace: Mt. Savage, Allegheny, Md.
(Town, county, and state)
10. Usual occupation: Celanese Spinner
11. Industry or business: Textile
FATHER 12. Name: John M. Shaffer
13. Birthplace: Md.
MOTHER 14. Maiden name: Eva Frankenberry
15. Birthplace: Pa.
16. Informant: John M. Shaffer
Address: Mt. Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 11, 1948 (month) (day) (year)
Cemetery or ~~crematory~~: Mt. Savage Methodist
Location: Mt. Savage, Md.
18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Pa.
19. 4-10 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 19 48, at 11 35 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 19 48, to April 8 19 48
and that I last saw h. alive on April 8 19 48

	DURATION
Immediate cause of death: Cholecystectomy Shock and Hepatitis	3 days
Due to: Gall Stones	
Due to:	
Other conditions: Pneumonia	2 days

(Include pregnancy within 3 months of death)

Major findings of operations: Gall Stones in Gall B. and in Common duct. Date of op. April 3-48
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. Alan G. Murray M.D.
M. D. or other
Address: Cumberland Md. Date signed: April 10

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03466

159

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Hyndman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Baby Girl Shroyer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4 / ~~29~~ 30 / 48

8. AGE: Years | Months | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace Allegany Co. Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Marshall Shroyer

13. Birthplace Pa.

MOTHER — 14. Maiden name Roberta Smear

15. Birthplace Pa.

16. Informant Marshall Shroyer

Address Hayndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 / 23 / 48 (month) (day) (year)

Cemetery or crematory Comps

Location Hyndman, Pa. R.F.D. # 1

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. April 23 19 48 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 48 at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 19 48, to Apr 22 19 48

and that I last saw h[illegible] alive on Apr 22 19 48

Immediate cause of death	DURATION
Pulmonary Atelectasis	3 days
Due to Pre mature gestation. (Twin)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE John A. Topper M.D. M. D. or other

Address Hyndman Pa. Date signed 4/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Mc Lane 03467

46a

Reg. Diat. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Midlothian
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midlothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clifton Walter Skidmore

3.(b) Social Security Number none

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Priscilla Skidmore
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 22 1886
8. AGE: Years 61 Months 6 Days 13 If less than one day ..... hrs. ..... min.
9. Birthplace: Borden Allegany Md. (Town, county, and state)
10. Usual occupation: mine operator
11. Industry or business: Coal mines
FATHER 12. Name: Matthew Skidmore
FATHER 13. Birthplace: Idaho
MOTHER 14. Maiden name: Jane Bone
MOTHER 15. Birthplace: Maryland
16. Informant: Royal Skidmore
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 7 1948 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. C. Debrist
Address: Frostburg Md.
19. 4-6 1948 (Date rec'd by registrar) Mrs Mabel K. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 5 1948 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1947 to Apr 5 1948 and that I last saw h— alive on Apr 3 1948

	DURATION
Immediate cause of death: Carcinoma of Oesophagus	1 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane M.D.
M. D. or other
Address: Frostburg Md Date signed 4-5-48

Within corporate limits

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b 03468

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 36 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County Hampshire

City or town [redacted] Romney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MRS. DOROTHY SMITH

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife WILLIAM ROY SMITH

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1901

8. AGE: Years	Months	Days	If less than one day
46	10	12	hrs. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name JAMES E. CLARK

13. Birthplace VIRGINIA

MOTHER

14. Maiden name ANNA MARY RINKER

15. Birthplace VIRGINIA

16. Informant Memorial Hosp.

Address Cumberland, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof APR. 4. 1948 (month) (day) (year)

Cemetery or crematory INDIAN MOUND CEMETERY

Location ROMNEY, W. Va.

18. Funeral director Myrl R. Coulter

Address Romney, W. Va.

19. April 7, 1948 (Date rec'd by registrar) W.F. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2- 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1948 to 4-2- 1948

and that I last saw h[illegible] alive on 4-2- 1948

Immediate cause of death	DURATION
Carcinoma of Liver (Primary)	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results See case Records

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams M. D. or other

Address Cumberland Date signed 4/3/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate Dr. Hawkins

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

100 b 03469

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~2 Days~~ 49 years

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 1120 SCHADES LANE (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. EMILY Susan SMITH

3.(b) Social Security Number None

4. Sex FEMALE

5. Color or race WHITE

6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife LAWRENCE E. SMITH

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 11, 1878

8. AGE: Years 70 Months 1 Days 29 If less than one day ... hrs. ... min.

9. Birthplace ~~MARYLAND~~ Somerset Co, Penna. (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business Own Home

FATHER 12. Name CARL LAUTERBACH

13. Birthplace GERMANY

MOTHER 14. Maiden name MATILDA COOK

15. Birthplace FRANCE

16. Informant Mrs Martha Albright

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Apr 13, 1948 (month) (day) (year)

Cemetery or crematory Trinity Lutheran Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19 April 13 1948 (Date rec'd by registrar) W. R. Fartz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 10, 1948 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1948 to April 10, 1948 and that I last saw her alive on April 9, 1948

Immediate cause of death Thrombophlebitis R. Femoral vein "Old Milk Leg"

Due to ~~Ac~~ Anterior Colporrhaphy colporrhaphy

Due to Perineorrhaphy

Other conditions Perineorrhaphy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Thrombi all way through [illegible]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE A. H. Hawkins M.D. or other

Address Cumberland Date signed 4-10

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

03470

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs 6 mos - 23 dys

Hospital, Institution, or street address where death occurred: East Main Street

How long in hospital or Institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Main Street (If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3. (a) FULL NAME: Isaac Aloysius Stakem

3. (b) Social Security Number: 216-05-5803

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta Helwig Stakem

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sept 29, 1887

8. AGE:

Years	Months	Days	If less than one day
60	6	23	...hrs. ...min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Stakem Shop

FATHER

12. Name: Patrick Stakem

13. Birthplace: Wicklow County, Ireland

MOTHER

14. Maiden name: Esther Mary Cavanaugh

15. Birthplace: Ireland

16. Informant: Daniel Stakem Sr.

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26, 1948 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetary

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md.

April 26 1948 Jankatte M Beal

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/22 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/5 1948 to 4/22 1948

and that I last saw him alive on 4/22/48 1948

Immediate cause of death: Congestive Heart failure

DURATION

Due to: arrhythmia

Due to: Undetermined

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work? -

23. SIGNATURE: Paul Eugene Dye, M.D. (M. D. or other)

Address: Lonaconing Md., Date signed 4/24/48

THE [illegible] COMPANY
LUNA[illegible]G, MD.
TO THE CREDIT OF
THE AVENUE MARKET

Within corporate limits

Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

03471

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank George Stierstorfer

3.(b) Social Security Number 215-26-9875

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minerva Felber.

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1894

8. AGE: Years	Months	Days	If less than one day
53	7	14	hrs. min.

9. Birthplace New York City, N. Y.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Cumberland Brewery

FATHER — 12. Name George Stierstorfer

13. Birthplace Germany

MOTHER — 14. Maiden name Mary Hoffman

15. Birthplace Germany.

16. Informant Homer Stierstorfer

Address 331 Dam Ave - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1948 (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. April 30 19 48 W. K. Frantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 48, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-23-48 19 to 4-28-48 19

and that I last saw h alive on 4-28-48 19

Immediate cause of death	DURATION
Carcinoma Stomach	3 yrs.
Due to	
Due to	
Other conditions Hypostatic Pneumonia	3 days.

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach Date of op

Autopsy results Yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. C. Zimmerman M. D. or other

Address Date signed 4-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr. Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47a

03472

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 124 Polk St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Francis Charles Stowell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Elizabeth Wilson

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1873

8. AGE:

Years	Months	Days	If less than one day
74	6	10	hrs. min.

9. Birthplace: Bloomington, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: David Stowell

13. Birthplace: Canada

MOTHER — 14. Maiden name: Margaret Casey

15. Birthplace: Mt. Savage, Md.

16. Informant: Mrs. Ann Hartung

Address: 328 Fayette St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 12, 1948 (month) (day) (year)

Cemetery or crematory: St. Patricks Cem.

Location: Mt. Savage, Md.

18. Funeral director: Charles L. George

Address: Cumberland Md.

19. April 12, 1948 (Date rec'd by registrar) W. L. Hauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 9, 1948 at 2:26A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1948, to April 9 1948

and that I last saw h... alive on April 8 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 hours
Due to: Exhaustion	6 hours
Due to:	
Other conditions: Arteriosclerosis	6 yrs.
(Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. Alan E. Murray M.D.
M. D. or other

Address: Cumberland Md. Date signed: April 10 48

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03473

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: yes 1st World War

3.(a) FULL NAME: Harry Sulser

3.(b) Social Security Number: 213-09-6606

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Theresa Reilly
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Aug. 30, 1882

8. AGE: Years: 65 | Months: 7 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Elk Garden, W. Va. (Town, county, and state)
10. Usual occupation: Coal Miner (Retired)
11. Industry or business: Ocean Mine

FATHER
12. Name: David Sulser
13. Birthplace: Unknown

MOTHER
14. Maiden name: Naomi Beaver
15. Birthplace: Unknown

16. Informant: Mary Naomi Sulser
Address: Midland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 19, 1948 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. 4-19 (Date rec'd by registrar) 1948 Mrs. Nancy L. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1948, at 10:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 16 1948 and that last saw h. I. M. alive on April 16 1948.

	DURATION
Immediate cause of death: Broncho-Pneumonia	4 days
Due to: Chronic Cystitis	10 yrs.
Due to: Myocarditis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. E. Gatten M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 4/18/48

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63 b

03474

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 907 Michigan Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: LILLIAN VAN METER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edwin V. Van Meter
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): July 2, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	11	hrs. min.

9. Birthplace: Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John W. Eackles
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Rachael V. Hawke
15. Birthplace: W. Va.
16. Informant: Mr. Edwin V. Van Meter
Address: 907 Michigan Ave., Cumberland,
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 17, 1948 (month) (day) (year)
Cemetery or crematory: St. Marys Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. April 16, 1948 (Date rec'd by registrar) W. L. Lantz, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1948, at 5:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 March, 1948 to 13 April, 1948 and that I last saw her alive on 13 April, 1948

Immediate cause of death	DURATION
Chronic nephritis with terminal uremia.	3 weeks
Due to: Hypertensive vascular disease	?
Due to: Hypertensive heart disease	?
Other conditions: Toxic adenoma of the thyroid.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Alfred Van Meter M. D. or other
Address: Cumberland, Md. Date signed: 15 Apr. 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03475

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town rural) Mexico Farms, near Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Rt. #4 Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ohio. County Summit ~~Allegany~~

City or town Cuyhoga Falls
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1927 N. Moreland Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME James Edward Viands

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife Lula Kline

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16-1873

8. AGE: Years	Months	Days	If less than one day
74	9	11	..... hrs. ..... min.

9. Birthplace Luray, Va. Page County
(Town, county, and state)

10. Usual occupation retired B& O.R.Ry. machinest

11. Industry or business

FATHER 12. Name Henry Viands

13. Birthplace Unknown

MOTHER 14. Maiden name Menervia Bowman

15. Birthplace Unknown

16. Informant Mrs. Myrtle Thompson

Address 400 Decatur St., Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1948 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 30 19 48 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 48 at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on April 28 19 48

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to coronary sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 4-28-1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03476

109(B)

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. St. Mary's Terrace (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Richard Graham Waddell

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Mary Nichols Waddell 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22 1881

8. AGE:

Years	Months	Days	If less than one day
67	1	23	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany, Md. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER — 12. Name: William Waddell

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Jane Graham

MOTHER — 15. Birthplace: Unknown

16. Informant: Wilbur Waddell

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15 48 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md

19. April 17 1948 (Date rec'd by registrar) Jeannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/15 1948 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1948 to 4/15 1948 and that I last saw him alive on 4/13 1948

Immediate cause of death	DURATION
Pneumonitis	
Due to Asthma	
Due to Miners	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: — Injured at work?

23. SIGNATURE: Paul Eugene Frye, M.D. (M.D. or other)

Address: Lonaconing, Md. Date signed: 4/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03477

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1 South Waverly Terrace
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: West Virginia County: Morgan
City or town: Paw Paw, rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edgar C. Wagoner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	17	hrs. min.

9. Birthplace: Morgan County, West Virginia (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm

FATHER
12. Name: John Wagoner
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Sarah Emma Milslagle
15. Birthplace: Virginia

16. Informant: Mrs. Howard E. Cooper
Address: 1 So. Waverly Terrace, City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 29, 1948 (month) (day) (year)
Cemetery or crematory: Levels
Location: Levels, W. Va.

18. Funeral director: W. D. Parks
Address: Berkeley Springs, W. Va.

19. April 27 19 48 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 19 48 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27/47 19 to 4/26/48 19
and that I last saw h[illegible] alive on 4/26/48 19

Immediate cause of death	DURATION
Myocardial Rupture	2 days
Due to: Chr Myocarditis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. H. Williams, M.D. M. D. or other
Address: Cumberland, Md. Date signed: 4/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160 C

03478

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 South Smallwood St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sandra Kay Walsh

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1948

8. AGE: Years	Months	Days	If less than one day
0	0	1½	..... hrs. ..... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Robert Walsh

FATHER — 13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Ethel Allen

MOTHER — 15. Birthplace: Green Spring, W. Va.

16. Informant: Mr. Robert Walsh

Address: 10 S. Smallwood St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 20, 1948 (month) (day) (year)

Cemetery or crematory: St. Patricks Cem.

Location: Mt. Savage, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 20, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 18, 1948, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from I day 1948 to 18 Apr 1948 and that I last saw h.. alive on 18 Apr 1948

Immediate cause of death	DURATION
Prematurity	
Due to: Placental Previa.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fuller B. Muhlenfeld M. D. or other

Address: 112 Bedford St. Date signed: 19 Apr.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS-A15

T

Within corporate limits

Dr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03479

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred: 109 Federal St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Federal St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Henry Wariner

3. (b) Social Security Number 212-10-6320

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Goetz

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Oct 8, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	19	hrs. min.

9. Birthplace: Ruffin, Rockingham, N. Carolina (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Automobile

FATHER — 12. Name: Robt Lucas Wariner

13. Birthplace: N. Carolina

MOTHER — 14. Maiden name: Ruth Ella Gurrant

15. Birthplace: N. Carolina

16. Informant: Mrs Robt H. Wariner

Address: 109 Federal St - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: apr 30, 1948 (month) (day) (year)

Cemetery or crematory: Sts Peter & Paul Cemetery

Location: Cumberland, Maryland

18. Funeral director: John J. Hafer

Address: Cumberland Md

19. April 30 1948 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: apr 27 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to April 27 1948 and that I last saw h... alive on April 26 1948

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions: Bronchial Asthma	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: 4-29-48

Within corporate limits

Rr. 2. B. 03480

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 234 Glenn St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Wells

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	3 hrs. 30 min.

9. Birthplace Cumberland, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Reginld H. Wells
13. Birthplace Cumberland Md.

MOTHER
14. Maiden name Lorraine Boyd
15. Birthplace Cumberland Md.

16. Informant Reginald Wells
Address 234 Glenn St. Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof April 27 1948
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland Md.

19. April 27, 1948 Wm. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1948 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1948 to April 26 1948 and that I last saw h— alive on April 26 1948

Immediate cause of death	DURATION
congenital malformation	
Due to	
Due to	
Other conditions premature baby (7 months)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L Klein MD
M. D. or other
Address 54 Seneca St. Date signed 4-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838

03481

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? THREE DAYS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? THREE DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: WEST VIRGINIA County: MINERAL

City or town: RT. # 1, RIDGELEY

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RT. # 1,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MRS. EFFIE WHITMAN

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: [redacted] WILLIAM WHITMAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 72 MARCH 17, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	13	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business

FATHER

12. Name: JOHN WILKINSON

13. Birthplace: MARYLAND

MOTHER

14. Maiden name: JOSEPHINE MARTIN

15. Birthplace: VIRGINIA

16. Informant: DR. RAYMOND W. WHITMAN

Address: 127 N. GRIME ST., MIDDLETOWN, OHIO

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 2, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetary

Location: Baltimore Pike

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. April 30 1948 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 30, 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1948 to April 30 1948 and that I last saw h[illegible] alive on April 29 1948

	DURATION
Immediate cause of death: Cerebral thrombosis	1 day
Due to: Arteriosclerosis	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Eliason M.D. M. D. or Coroner

Address: 136 Greene St Cumberland Md. Date signed 4/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03482

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

121 Ormond St.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Ormond St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Veronica Wilson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John A. Wilson

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 12 - 1884

8. AGE: Years: 63 | Months: 9 | Days: 12 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Canacaunga, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Miss Mary Wilson

Address: 121 Ormond St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-27-1948 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Kaster

Address: Frostburg, Md.

19. 4-27 1948 (Date rec'd by registrar) Miss. Nancy V. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1942 to Apr 24 1948 and that I last saw her alive on Apr 21 1948

	DURATION
Immediate cause of death: Hypertension	>4 yrs
Due to: Cerebral Hemorrhage	2 wks
Due to: Rt Hemiplegia	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W O M Lane M.D.

M. D. or other

Address: Frostburg Md Date signed 4-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

to Mc Lane

03483

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, institution, or street address where death occurred: Hill Top Drive

How long in hospital or institution? - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hill Top Drive

(If rural, give LOCATION)

2.(a) If veteran, name war - - - - - - - - - -

3.(a) FULL NAME: JOHN WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louise Holler Wilson

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 21, 1882

8. AGE: Years	Months	Days	If less than one day
65	11	22	....hrs. ....min.

9. Birthplace: Westernport, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER 12. Name: Jacob Wilson

FATHER 13. Birthplace: Lost River, W. Va.

MOTHER 14. Maiden name: Mary Jones

MOTHER 15. Birthplace: Moorefield, W. Va.

16. Informant: Jacob Wilson

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. April 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 (13) 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Apr 13 1948 and that I last saw h. l.m. alive on Apr. 11, 1948

Immediate cause of death	DURATION
Cancer of Stomach	6 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

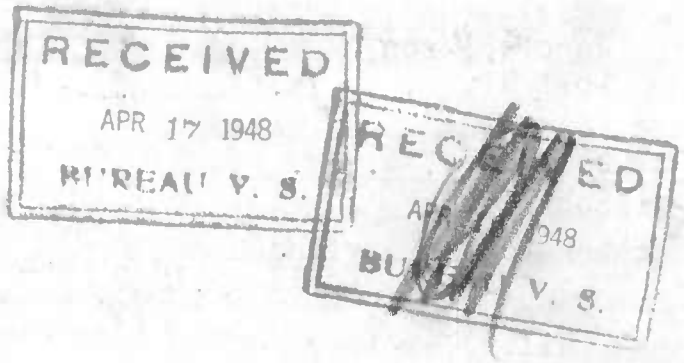
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul R. Wilson M.D. M. D. or other

Address: Piedmont, W. Va. Date signed: 4-14-48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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03484

8

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

~

How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No. ~

(If rural, give LOCATION)

2.(a) If veteran, name war ~

3. (a) FULL NAME George Walter Winters

3. (b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife ~

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1869

8. AGE: Years	Months	Days	If less than one day
78	7	9	..... hrs. ..... min.

9. Birthplace Farm near Midland, Md. (Town, county, and state)

10. Usual occupation Farming

11. Industry or business Own Farm

FATHER 12. Name Jacob Winters

13. Birthplace (Farm) Midland, Md

MOTHER 14. Maiden name Louisa Humberstone

15. Birthplace Unknown

16. Informant Mrs Maria Muir

Address Midland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16 48 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. April 16 1948 (Date rec'd by registrar) Jeannette M Bord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 13th 1948, at 8:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to 4/13 1948

and that I last saw h.i.m alive on ..... 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul Eugene Drye M.D.

M. D. or other

Address Lonaconing, Md Date signed 4/13/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03485

13a (D)

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegheny
City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Somerset
City or town: Wellersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Alice Louise Witt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George Washington Witt
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 29, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	13	hrs. min.

9. Birthplace: Broadtop Bedford Penna.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Domestic

FATHER
12. Name: Henry Moser
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Hayman
15. Birthplace: Germany

16. Informant: Gertrude Delbrook
Address: Corriganville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 13 1948 (month) (day) (year)
Cemetery or crematory: Zion Reformed Church
Location: Wellersburg, Penna.

18. Funeral director: Harvey A. Zeigler
Address: Hyndman Penna.

19. April 13 1948 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 April 1948 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1942 to Apr 1948 and that I last saw her alive on 10 April 1948

Immediate cause of death	DURATION
Chronic Arterio-Sclerotic Cardio Renal Disease	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Tappe MD M. D. or other
Address: Hyndman Pa. Date signed: 4/11/48